PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____

Social Security Number: _____-_____-_____ **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Address: _____ **Apt./Lot #:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Home Phone:** _____

Cell Phone: _____ **Work Phone:** _____ **Email:** _____

In case of emergency, who do we contact? _____

Contact Number: _____ **Relationship:** _____

Primary Care Physician: _____ **Telephone #:** _____

How did you hear about us? Please check all that apply.

☐ **APTC staff member** Staff member's name: _____

☐ **Family or Friend** Referral name: _____

☐ **Special Event/Expo/Healthfair** If so, which event?: _____

☐ **CrimFit Adult Training Program** (circle one) Walker Runner
Training Group #: _____

☐ **Crim Festival of Races** ☐ **Color Me Davison 5k or other local race/sporting event** If other, which event?: _____

☐ **Posters** ☐ **Flyers** ☐ **Postcards** ☐ **Newspaper or Publication**
Which newspaper or publication?: _____

☐ **Senior Center Program** If so, which senior center/program?: _____

☐ **Parks & Rec. Program** If so, which location and program?: _____

☐ **School** If so, which school/program?: _____

☐ **T.V.** ☐ **Radio** ☐ **Billboard** ☐ **Internet Search** ☐ **Website Ad**
☐ **Facebook** ☐ **Twitter** ☐ **Other Social Media**

☐ **Worker's Comp./Auto /Case Manager.** If so, please be sure to fill out the WC/Auto information section listed below.

☐ **Doctor:** His/her name: _____

Other or not listed Please specify: _____

Please complete the following only if subscriber is not the patient or is a minor: **Relation to Subscriber:**

Subscriber Name: _____ Date of Birth: _____ (circle one) Spouse Child Other

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Are services related to a work or auto injury? (Please circle one if applicable.) **Work** **Auto**

Date of injury: _____ Claim Number: _____ NCM or Adjuster Name: _____

Insurance Carrier: _____ Telephone: _____ Ext: _____

Employer: _____ Supervisor or Contact Name: _____

Employer Address: _____ Employer Phone: _____

Work Status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Disability ☐ Not Working

Assignment of Benefits:
I hereby assign all medical benefits, to include major medical health benefits to which I am entitled, including Medicare, private insurance and any other health plan to Advanced Physical Therapy Center, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. If I receive direct payment from my insurance company for my treatment, I will be responsible to bring this payment to Advanced Physical Therapy Center, P.C. to be applied to my account for services rendered. I certify this information is true and correct to the best of my knowledge.

Authorization for Release of Medical Records:
Advanced Physical Therapy Center, P.C. is authorized to provide and request from my referring physician, other physicians and/or my attorney, information regarding my diagnosis and medical condition for physical therapy while under their treatment. Information to be disclosed may include nature of the physical impairment, history, contributing factors, subjective symptoms, diagnosis, prognosis and other information pertinent to my treatment. Photostatic copy of this authorization shall serve in its stead.

Consent to Evaluate and Treat:
I, consent to evaluation and treatment by Advanced Physical Therapy Center, P.C. **(If patient is a minor, parent or guardian must sign below.)**

Signature: _____ **Date:** _____

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